

# ADDRESSING GENDER ISSUES WITH MEN AND COUPLES:

## Involving Men in Sexual and Reproductive Health Services in APROFE, Ecuador

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## **INTRODUCTION: PROGRAMS THAT FOCUS ON GENDER ISSUES AND MALE INVOLVEMENT IN SEXUAL AND REPRODUCTIVE HEALTH**

Governments, organizations, and individuals worldwide are grappling with the implications of the paradigm shift from population control to sexual and reproductive health that was embodied in the International Conference on Population and Development (ICPD) Programme of Action.<sup>1</sup> The central challenge has become translating laudable general principles of concern for comprehensive human well-being, human rights, and women's empowerment into concrete changes at all program levels. Case studies such as this one can help to illustrate successful attempts to integrate these ICPD principles into programs and to analyze facilitating factors and obstacles in these experiences.

Implementing the ICPD frameworks demands processes of cultural change within health services and other institutions. How does an institution organize the effort to swim against the tide of the prevailing culture and traditions in order to address gender issues? What is the process to effect internal change within an institution, and how can an institution keep reinforcing this change? These change processes are complex and provoke resistance; they demand political will from the leadership, resources, and systematic interventions. What factors affect whether or not the change interventions will be successful?

This working paper examines one institution's experience to shed light on these questions. The paper is drawn from a larger case study on incorporating ICPD principles and gender issues into the program of APROFE (Association for the Benefit of the Ecuadorian Family), which is the affiliate in Ecuador of the International Planned Parenthood Federation's Western Hemisphere Region (IPPF/WHR). Beginning in the late 1990s, APROFE undertook a concerted male-involvement initiative that dovetailed with its efforts to become more financially sustainable, as well as to diversify its services, improve quality of care, and incorporate a commitment to gender equity throughout its national network of reproductive health clinics.

APROFE's experiences with promoting male involvement closely follow those of the family planning field as it was transformed into the field of sexual and reproductive health. Although one well-known demographer identified the need to involve both men and women in family planning services as early as 1962,<sup>2</sup> during the next two to three decades, most demographic surveys and family planning services focused solely on women. It was not until the mid-1980s and early 1990s that the family planning field began to give serious albeit limited attention to men. From 1984 through 1994,<sup>3</sup> most family planning agencies' expectations from "male involvement" were limited to men's increased use of birth-control methods—condoms and vasectomies—and their decreased opposition to women's use of contraception.

Leading up to ICPD, mounting pressure to broaden this focus came during the late 1980s and throughout the 1990s, as the world's attention focused on the urgent need to stem the spread of HIV/AIDS. Preventive efforts mandated that men of all sexual orientations be involved in promoting sexual health. Family planning services, by definition, serve sexually active people and therefore constitute a natural venue for providing sexual health education and services. The international women's movement also put pressure on the field to broaden its narrow focus on family planning. National, regional, and international coalitions advocated that population programs and policies, rather than emphasizing population control, should adopt a central focus on achieving comprehensive individual well-being and rights in reproductive and sexual health. These movements promoted women's empowerment and gender equity not only as ends in themselves but also as a key factor in achieving sexual and reproductive health.

These pressures resulted in a sea change at ICPD in Cairo in 1994. Attention to male "participation and responsibility" in the ICPD Programme of Action<sup>4</sup> placed this participation

squarely within the framework of women's empowerment and comprehensive sexual and reproductive health. Men were to assume an equal role in caring for sexual and reproductive health, in shouldering their fair share of domestic responsibilities, and in promoting equality between the sexes. These paragraphs in the Program of Action stimulated much attention to the subject of male participation in the sexual and reproductive health literature, and among national and international agencies.<sup>5</sup>

### **PURPOSE AND METHODOLOGY OF THE CASE STUDY**

Case studies bring rhetoric to life, and in doing so, they serve multiple purposes. This case illustrates the process of transforming the rhetoric of ICPD on gender equity and male involvement into reality in a particular context.<sup>6</sup> It describes the organizational change process needed to implement these ICPD principles, as viewed by the participants. By illustrating common tensions and challenges, the case aims to help other programs to visualize a similar effort, and learn from the successes and failures, keeping differences in context in mind. Finally, this case can generate hypotheses for future program-related research and evaluation.

In APROFE's male-involvement initiative, providers systematically encouraged women to bring their male partners to the service. The initiative also used mass media and other means to encourage men—both individually and in couples—to use APROFE's services. As the number of men using the services began to rise exponentially, health providers were confronted with new situations and dilemmas—that a new type of client demanded different treatment—and in response, devised solutions to the problems that arose. The male-involvement initiative dovetailed with the institution's push to incorporate gender perspectives in its services. This case study examines how APROFE's successful efforts to encourage men to use its services created issues of quality of care, gender, and women's rights that had to be dealt with throughout the organization, and not just on an ad-hoc basis.

The data for this study comes from two main sources: a generous supply of APROFE documents that describe meetings and events related to the gender-training process; these were written by the members of the Information, Education, and Communication (I,E,&C) Department,<sup>7</sup> who were in charge of gender training, and by the Director of Evaluation, Agustín Cuesta; and semistructured in-depth interviews conducted by the author during a 10-day period in July 2000.<sup>8</sup> The author interviewed members of the I,E,&C department in APROFE in charge of the gender training, authorities at APROFE headquarters in Guayaquil, and a range of providers—from clinic supervisors and obstetrician/gynecologists to nurse's aides and receptionists—at four of the clinics where training took place in the cities of Machala, Cuenca, and Guayaquil (Alborada and Mapasingue). These clinics represent distinct cultural areas and clinic sizes, and all were evaluated by the gender training team as having a positive response to gender training.

The study has some limitations and biases. First, the data come entirely from the providers' viewpoint; with the exception of findings from male focus groups, the users' voice is absent. Second, the interviews provided a snapshot of the situation at one point in time in APROFE in mid-2000, with many steps leading up and following the state of affairs described here. Some data came from documents and telephone interviews that took place at a later date. Third, providers' interviews naturally suffer from social bias—that is, from people's tendency to give the most acceptable response. At least, these reports of providers' practice represent the norms that providers know that they should follow. Despite this bias, many APROFE providers were frank about the problems and obstacles that they have encountered.

The interviews focused on providers' experiences with and opinions about gender training, as well as examples of how the staff incorporated gender issues into their daily practice, thoughts on the relationship between quality of care and attention to gender, and areas that need improvement. Male involvement became a central theme of the interviews; it was not the original focus of the study.

## THE COUNTRY AND INSTITUTIONAL CONTEXT

With 13 million inhabitants, Ecuador is one of the smallest countries in Latin America, but one of the most culturally and geographically diverse. Twenty-five percent of its population are indigenous minorities, and climates range from coastal heat and humidity to Andean highlands to tropical rainforest. Ecuador's economy is dependent on sale of commodities such as oil and bananas, and increasingly, on tourism. It is also one of the region's poorest countries, ranking 125th globally in GNI per capita.<sup>9</sup> In 1995, 35% of the population were living below Ecuador's official poverty line, and 52% were earning less than \$2 a day.<sup>10</sup> According to UNICEF statistics,<sup>11</sup> maternal mortality rate is 210 per 100,000 live births and infant mortality is at 25. Recent studies in Ecuador show that the fertility rate has fallen to 3.4.<sup>12</sup> Ecuador has almost universal primary school enrollment, and literacy rates for adult men and women are in the high 90s.

Paolo Marangoni, a physician and successful businessman who immigrated to Ecuador from Italy in 1955, and Francisco Parra, an endocrinologist—both of whom were residents of Guayaquil—founded APROFE in 1965. They united a group of 15 initial founders, including three women, to open a family planning clinic.<sup>13</sup> Dr. Marangoni initially was the president of the board, and has been the executive director since 1969. The association attracted members in other cities, and clinics opened in two other major cities in Ecuador—Quito and Cuenca. APROFE now has 20 clinics in 15 cities and towns nationwide.

Dr. Marangoni's initial motivation for starting a family-planning service was his concern about population growth, a vision that amplified in response to advances in knowledge and the profound changes in the population field. From the 1970s through the 1990s, like most IPPF affiliates in Latin America, APROFE concentrated on family-planning services and received the bulk of its financial support from USAID and IPPF. By 1995, it became clear that these donors, as well as others from Canada and the Netherlands, would be significantly decreasing their support, and in the case of USAID, would halt aid altogether by the end of 2001. For reasons of economic survival, APROFE has concentrated on increasing its income by increasing its number of clients, while trying to keep unavoidable fee increases to a minimum. The organization is slowly and steadily succeeding in increasing usage. In 2001, the number of clinic visits totaled 404,817, a 7% increase from the previous year.

Ecuador suffered an acute economic crisis in 2000, the result of drastic devaluation of the *sucre* and the dollarization of the local economy, making APROFE's push for sustainability especially challenging. Despite efforts to keep fees affordable, without health-sector reform that guarantees universal access,<sup>14</sup> the need to attract large numbers of paying clients has changed its user profile.

*Before, the users were very poor people, because APROFE served people for practically nothing and gave contraceptives free. When we lost our financial support, APROFE had to begin to cover its costs and we raised our fees. As a result, all of our former clients have slipped away. Now we have a different type of users, the newly impoverished middle class—bank workers, secretaries, etc.—and we no longer serve poor users from urban slums. Doctor<sup>15</sup>*

*Antes las usuarias eran gente muy humilde porque antes APROFE prácticamente regalaba las consultas, y regalaba los métodos pero de pronto se quitó el financiamiento y APROFE empezó a solventarse y empezamos a subir la consulta y toda esa gente se nos ha ido apartando. Ahora hay otro tipo de usuaria, la clase media empobrecida que asiste de bancos, secretarias y ya no tratamos a usuarios pobres de urbano—marginal. VIII,3, Doctor*

Several other APROFE providers have also pointed out that the user profile has changed considerably, with more lower-middle-class and recently impoverished users who demand a much higher quality of attention than the average user had previously required. A small number of family planning users are still subsidized, and APROFE's ultimate goal is to use profits from paying clients to subsidize those who cannot pay.

APROFE's push toward self-sufficiency has been very successful. As of February 2003, the organization is receiving no support from USAID and survives mainly on service fees.<sup>16</sup> APROFE's success is due to five main strategies for increasing paying clients:

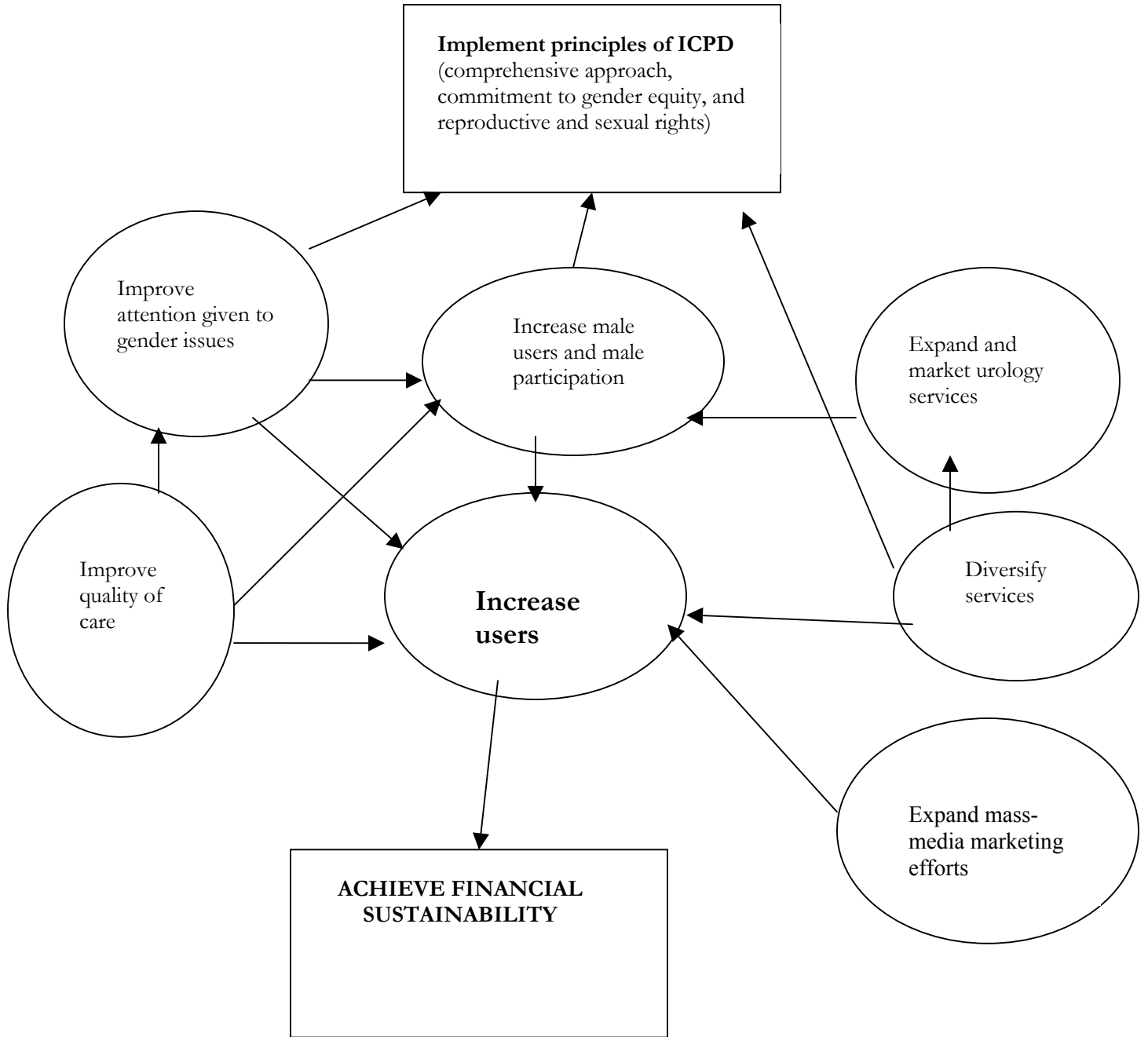
- Diversifying its services
- Increasing marketing activities
- Incorporating gender perspectives in the services
- Improving quality of care
- Devising strategies to increase service to men

Not only have these five strategies brought about greater sustainability, but they have also helped the institution incorporate the principles endorsed at ICPD, such as commitment to gender issues and to a more comprehensive sexual and reproductive health framework. (The graph on the following page illustrates these synergies.) The shift from family-planning services to sexual and reproductive health services has contributed to APROFE's strategy of diversifying services. ICPD's focus on women's empowerment led to APROFE's organizationwide training program to incorporate gender perspectives in their services; this initiative in turn has been key to its overall efforts to improve quality of care and has helped APROFE serve men appropriately. Its marketing and other strategies were designed to shift its public image from a women-only clinic. Its diversification efforts included adding sexual health and urology services, which was also important in attracting men and helping women persuade their partners to come to their next visit. This study suggests that diversifying services, improving quality of care, and incorporating gender issues are prerequisite to encouraging men to use reproductive and sexual health services. A similar case study conducted with Profamilia in Colombia<sup>17</sup> also demonstrated that the strategies to increase users and improve financial sustainability and the strategies to incorporate the principles of ICPD reinforced each other in key ways. The director of Profamilia, María Isabel Plata, explained these in an interview with the author:

*Diversification of services and involvement in women's rights, adolescent programs, and men's services have caused more youth, women, and men to come to Profamilia. When we give talks on these topics, it opens the doors to other institutions [with whom Profamilia gains contracts]. For example, the talks on rights and self-esteem opened the door to collaboration with Family Welfare [a major government agency]. . . . Thus, implementing the principles of holistic care, gender equity, and sexual and reproductive rights prepared Profamilia for the changes brought by Law 100 [health reform law]. . . . If we had not taken advantage of the principles approved in Cairo and Beijing, we would not have had success under Law 100. Everything acted in concert: our financial needs, the changes in the health sector, the withdrawal of USAID, and our adoption of these principles.*

The following graph illustrates this point.

**APROFE's Strategies: ICPD Principles Reinforce Strategies For Financial Sustainability**



## POTENTIAL BENEFITS OF MALE INVOLVEMENT

Two main incentives drove APROFE's male-involvement initiative: 1) In APROFE's push for financial self-sufficiency, attracting more men is an important opportunity to increase its number of users of services that previously were used primarily by women; 2) APROFE's providers understood that the sexual and reproductive health care they offered would be more effective if they treated couples and addressed gender issues with couples. From their experiences with women, they understood that male partners' opposition or nonparticipation have often prevented women from avoiding unwanted pregnancies and seeking treatment for sexually transmitted infections (STIs). APROFE's Director of Evaluation, Agustín Cuesta, explained:

*Involving men in sexual and reproductive health, either through having them accompany women or through having them be users in their own right, makes it possible to ensure their support for women's decisions and helps us keep users coming regularly. [Involving men] also means that we can attract a population that has never come to our services before.*

*Involucrar a los varones en la salud sexual y reproductiva como acompañantes de sus parejas o como usuarios por sí mismos abriría puertas para garantizar el apoyo a las decisiones de las mujeres y posibilidades más amplias de contar con usuarias fieles a los servicios. De igual forma, significaría atraer como usuarios de los servicios a una población que hasta entonces no concurría.*

Cuesta, "Antecedentes," 2000

Several providers spoke eloquently about the advantages of involving men, who can make the visit a positive experience for the couple and improve health outcomes by engaging men in protecting women's health during pregnancy.

*Generally, men really love babies. [Especially for the first two or three pregnancies] the man is always there with the woman, touching her belly, seeing how we examine her . . . When they don't come, we try to persuade them to come to at least two or three of the prenatal visits, especially in difficult situations where the woman is in pain or nauseous . . . In that case, we aim to have him take greater responsibility for household work. Doctor*

*Generalmente el hombre es muy "guagüero" . . . Y están siempre ahí, junto a la señora, le está tocando la barriga, quiere ver como la examinan . . . Los primerizos siempre están con pareja, en prenatal. Y en los que no, tratamos de inculcar que asistan por lo menos a unas dos o tres consultas de las que acude la esposa, especialmente en situaciones difíciles, en dolencias, nauseas . . . Ahí lo que queremos es que él comparta responsabilidades, que le ayude en el hogar . . . XI, 3, Médico*

From the point of view of sexual health, the most apparent benefit of male involvement is that in diagnosing STIs, both members of the couple receive information, counseling on risky practices, and treatment. Upcoming sections of this paper illustrate the difficulties involved with achieving this seemingly simple goal.

Some examples of the advantages of involving both men and women emerged while using a gender perspective to deal with sexuality issues. One doctor stood out for her grasp of common gender issues behind sexual problems reported by women.

*Many times, we see patients with sexual problems who . . . think that the cause is physical when in fact we find that the sexist customs within the couple cause her to submit to sexual relations when*

*she has no desire to do so. . . . Using a gender focus we help her to understand that she can say when she feels desire and when she does not, whether due to some physical cause or being tired from housework. We invite her spouse so that we can explain to both of them the importance of equal participation in the sexual relationship. The women complain that they have never had an orgasm and tend to think that they are at the root of the problem, when actually their partners are not helping them [to get excited].*

*Muchas veces, en consulta, tenemos pacientes con problemas sexuales, . . . y piensan que la causa es mas de tipo fisica, cuando en realidad hemos descubierto que son las costumbres machistas que han reinado en la pareja lo que ha hecho que muchas veces, ella acceda a la relación sexual sin tener el deseo sexual. . . . A través del enfoque de género le hemos hecho entender que . . . ella puede manifestar cuando ella puede tener el deseo sexual, cuando ella no puede tener, por alguna causa fisica o por su cansancio por su trabajo en el hogar. Hemos invitado a la pareja para que venga a la consulta, para explicarles que es importante que los dos participen en la relación sexual. Ellas se quejan mucho de que no saben ni lo que es el orgasmo y estiman que la causa es de ellas, que de ella dependía todo y, vemos, en la realidad, que es la pareja la que no está colaborando con ella. XVI, 2*

## **OBSTACLES TO MALE INVOLVEMENT**

Professionals in reproductive health recognize that it is more difficult to get men to use reproductive health services than it is to get women into a clinic. (Robey & Drennan, 1998:16) The reason for this gender-based discrepancy is that men are less willing than women to admit that they are ill or to take care of their health in general (Best, 1998:37; Claux, 2001:8-9, Green & Pope, 1999).<sup>18</sup> Also, unplanned pregnancies have less of an impact on men than on women. Consequently, men do not view the need for sexual and reproductive health services as urgently as women do. Strategies to attract men must therefore be multifaceted, emphasizing the importance of their and their partner's health. (Wegner et al., 1998: 32)

Other logistical and sociocultural barriers can hamper male involvement. For instance, clinic hours often need to be adjusted so that men who work full-time, or more, can make their clinic appointments without jeopardizing their livelihoods. Also, according to APROFE providers, men sometimes care for the children so that women can visit the clinic.

Once men arrive in the clinic, other sociocultural barriers arise. APROFE providers observed that male stereotypes perpetuated by providers as well as female partners can create an obstacle men's involvement. Furthermore, APROFE providers noted that men can be more demanding than women and are less tolerant of poor quality of care. The following sections analyze in-depth each of these barriers.

### **Male Attitudes Toward Health Care**

It is well documented in the literature that when men feel ill, they tend to "tough it out," which can pose a significant health risk. (Best, 1998:37) (Sanhueza, 2001:1) (Claux, 2001:8-9) Often, men will seek medical care only when their illness has advanced to the point that it is difficult if not impossible to treat. This behavior is apparently based on the expectation that men are not supposed to show weakness or to complain about pain. (Greig et al, p. 22)

*Men do not like to go to the doctor or to be sick, because for a real macho, sicknesses do not affect them. It is part of the patriarchy and ancestral customs. For this reason, a man will not come to see a doctor until he is really badly off, at which point it may be too late to help him. Doctor*

*A los hombres no les gusta ir al doctor y estar enfermo. Porque el hombre es macho, a él ni las enfermedades le hacen nada . . . es un patriarcado . . . de ancestro . . . una costumbre. De ahí viene eso de que el hombre no acude al médico sino cuando ya está mal y, a veces, cuando ya no hay nada que hacer. XI, 3, Médico*

This widely recognized problem has assumed added urgency and garnered much greater attention after the outbreak of the HIV/AIDS epidemic, because men's unwillingness to seek care has put their wives and all other sexual partners at risk. The APROFE gender-training team and many providers have recognized this tendency and its basis in gender roles.

One APROFE director commented that men will go to great lengths to avoid submitting to a doctor's care; the word "submit," which implies being put in a powerless position, may be key to their resistance. Male discomfort in the role of the "patient" is so pronounced that often when wives accompany their husbands, the husband is silent and the wife does all the talking, which is the reverse of the usual pattern of conversations being male dominated.

*[after describing the usual pattern] When he is sick, his wife does all the talking. . . . Doctor*

*[Despues de describir el padrón] Cuando él es el enfermo es la señora la que habla, XI,3, Médico*

To avoid what they consider the demeaning experience of going to a doctor, men tend to self-medicate in pharmacies following their friends' or pharmacists' advice, a practice that often fails to address their health problem appropriately.<sup>19</sup>

### **Stereotyped Attitudes Toward Men**

For APROFE, the most successful strategy for increasing the number of male clients has been to have the providers as well as their partners personally invite them to participate. However, both providers' and female partners' stereotypes about machismo may lower their expectations about whether men will cooperate. Low expectations can be self-fulfilling when no attempts at all are made to invite men to services. Transforming gender roles involves changing these socially derived expectations and attitudes. To do this, APROFE's training program involved overturning providers' long-held assumptions about men's unwillingness and disinterest. Providers must then work with women's assumptions.

*Sometimes the woman anticipates his response and says, "He won't want to [come to the clinic]." We assume that he is machista, but maybe he isn't, and we are just prejudiced. [Sometimes] when we [finally] talk with the male partner he says, "See, I told you that I could help out." However, there are also cases of men who are much more resistant. Maybe in the clinic they seem to accept our advice, but once they leave, they don't. Clinic supervisor*

*A veces la mujer dice, "el no va a querer" se anticipa a la cosa y pensamos que él es machista y a lo mejor no lo es, sino que estamos con ese prejuicio por delante y cuando conversamos con la pareja él dice: " Ya ves que te dije yo también puedo ayudar y colaborar." Pero también hay casos en que son mucho más recios, talvez aquí aceptan, pero cuando salen, no. IX,9, Supervisora*

As this provider pointed out, in some cases, the negative stereotypes were realized, but APROFE's success in attracting men demonstrates that they are not true for a significant number

of men. Many men, when it is clear that both providers and their female partners expect them to participate, respond positively. Clearly, it is self-defeating to act on negative assumptions.

### **Childcare Issues**

When the male partner cares for the children while his partner goes to the clinic, getting both into the clinic may involve arranging for child care. In other instances, a woman's partner and children accompany her to the clinic, and her partner looks after the children while the woman sees the doctor. In this case, encouraging male involvement can create some inconveniences.

*Just the other day, a woman came for her prenatal checkup. Her husband came with her two little boys . . . [After I invited the husband in] those two kids turned my office inside out! What antics! . . . And yet, we can't tell them to not come in. Doctor*

*Ahora, justamente, vino una señora para un control prenatal. Vino el esposo, y vino con dos criaturitas varones . . . por poco me ponen patas para arriba el consultorio, pucha, qué travesuras de la guaguas . . . pero tampoco hay cómo decir que no pase. XII,2, Médico*

Clinics that are committed to serving couples may need to ask the woman explicitly about this issue. If the spouse comes to the clinic, he may have to bring the children if no other caregiver is available. Clinics could consider such solutions as providing temporary child care or space for supervised play while a couple sees a doctor or midwife.

### **QUALITY OF CARE BARRIERS**

Men's traditional roles make them less willing to put up with disrespectful treatment or other problems with quality, and less willing to tolerate the hierarchical nature of the doctor-patient relationship. Dr. Alfonso López Juárez, Director of MEXFAM, has commented: "Men do not like the doctor to give them orders." On the other hand, women's traditionally subordinate roles have often led them to passively accept disrespectful treatment, hierarchical relationships, and other types of poor conditions. The focus-group study pointed out the need for a serious quality-of-care initiative, not only because it would be the right thing to do but also because clients who were paying higher fees and men of all economic classes would not use the services unless quality of care improved. Fortunately, improvements in quality of care that were needed to attract and retain male clients have also benefited women. One aspect of APROFE's quality-of-care and gender training, was to examine men's perceptions and needs and to emphasize the importance of treating both men and women with *calidad con calidez*—that is, quality with warmth. Within the network of IPPF/WHR affiliates, the aim of several training programs, including APROFE's, was to transform the tendency of biomedical personnel to treat the body, and not the whole person.

### **EARLY HISTORY OF MALE INVOLVEMENT IN APROFE: MALE CLINIC, 1991–1993**

In September 1991, APROFE opened an independent service—a men’s clinic in Guayaquil that focused on promoting the use of vasectomies and urology services, including detection and treatment of STIs. The clinic was established in response to a general push in the family-planning field to involve men in contraception, and to move away from over-reliance on female sterilization, which is a much riskier procedure than vasectomy. At the time, family-planning clinics tended to be women-only spaces, and APROFE and other agencies believed that male-only clinics would be the most effective strategy to increase the number of male clients. They were encouraged by the well-publicized initial success of the Pro-Pater Clinic in Brazil. Starting in the late 1980s and mainly with support from Association for Voluntary Surgical Contraception,<sup>20</sup> several IPPF/WHR affiliates established male clinics, including Profamilia in Colombia, MEXFAM in Mexico, the Family Planning Association of Trinidad and Tobago (FPATT), and more recently, INPARRES in 1999 in Peru.

While all of the men’s clinics provided a variety of reproductive- and sexual-health services, the principal evaluation criterion for their main donor (USAID) during the 1980s and most of the 1990s was “couple-years of protection” (CYPs), which translated in reality into numbers of vasectomies.<sup>21</sup> In Ecuador, despite intensive marketing of the APROFE services to men, the services were very underutilized, and the experiment only lasted two years. APROFE directors give several reasons for the underutilization, and for their decision to close the male clinic.<sup>22</sup>

#### **It took a long time and many strategic, personal interactions to transform the public image of the family planning association from a service that was for women only to one that was available to the entire family.**

For APROFE, radio broadcasts geared to men were ineffective in counteracting this for-women-only image and did not bring sufficient numbers of men to the clinic for urology or family planning. An APROFE focus-group study of men (Cuesta, 1998) showed that despite the intense marketing campaigns from 1991 through 1993, men viewed APROFE clinics as inhospitable to men and as women-only spaces. APROFE later realized that female users who invited men to the clinics did the most to change the clinics’ women-only image and to attract more men to their services.

#### **The market for vasectomy services was not large enough to make the clinics self-sustaining or to generate continued donor support.**

As mentioned above, for the donors the key criterion was number of vasectomies or CYPs. APROFE did not earn any CYPs for urology services provided, or for STI exams. Making vasectomies acceptable has continued to be a difficult, long-term process. “. . . men’s squeamishness about this particular surgery is well-known.” (Helzner, 1996, p. 150)

#### **Separating services by sex proved impractical and unnecessary.**

Although the men’s clinic was the first step in increasing male users’ visits to APROFE, those who wanted a vasectomy still had to go to the women’s clinic, since duplicating a surgical infrastructure did not make sense. Furthermore, the long lines in the women’s clinic and the empty waiting rooms in the men’s clinic caused an “invasion” of the men’s clinic by women’s-clinic patients who wanted to avoid a long wait.<sup>23</sup> As a result, men’s-clinic providers, who were underutilized, began serving women as well.

In summary, the inability to attract sufficient numbers of male users combined with the breakdown of the sex-segregated nature of the service clearly showed APROFE directors that the

men's clinic was a failed experiment. So in 1993, two years after the men's clinic had opened, the directors decided to cut their losses and shut down those facilities.

It is interesting to compare APROFE's experience with its men's clinic to those of IPPF/WHR affiliates in other countries. APROFE's clinic suffered from starting in a historical period when number of vasectomies was most important to the donors. In addition, APROFE's finding that sex segregation was not necessary echoes the experience of MEXFAM in Mexico, who also closed their clinic after two years of operation from 1988 to 1990. MEXFAM's director comments<sup>24</sup> that most men were brought in by their spouses, so that having a separate male space proved unnecessary. He also notes that the model was too costly because it duplicated administrative costs and infrastructure.

In Bogotá, Colombia, however, Profamilia's men's clinic—which predated both the Ecuador and Mexico clinics—has continued to prosper, serving mainly male clients, as well as female clients who seek sexual-health services, especially STI testing. Hiring a sexologist has also helped to attract more male users.<sup>25</sup> In Peru, INPPARES started a men's clinic in 1999 that provides a full range of sexual- and reproductive-health care and has seen gradual but steady increases in numbers of clients, with a 65% increase from 2001 to 2002.<sup>26</sup> Yet INPPARES knows that the sociocultural barriers to male involvement mean that it will take at least five years before community education can bring enough male users to the clinic so that it can achieve financial sustainability. Because community-education programs rarely attract donors, organizations must make a significant investment in its early years in a men's clinic so that it can be sustained. Combining some operational services (such as bookkeeping and clerical duties) with the women's clinic and diversifying the supply of services is contributing to the financial health of the clinic. In contrast with MEXFAM's experiences, many men prefer to come to the INPPARES clinic without their spouses or partners.

Later developments in APROFE and in the family-planning field have further reinforced the wisdom of APROFE's decision to close the men's clinic. Once they received training in quality-of-care and gender issues, APROFE directors and providers realized that providers in the men's clinics had not been prepared to deal appropriately with men. The concept of "appropriate" in male involvement has two dimensions. First, understanding gender differences enables providers to understand how men face different problems and risks, and thus need an approach that is different from women. Second, without gender training, providers may inappropriately reinforce gender stereotypes, especially when they appeal to men's desire to control women's sexuality and to their jealousy in order to secure men's acceptance of family planning. (Blanc, 2001, 26) In ill-conceived attempts to remove men's opposition to using condoms or having a vasectomy, providers have been known to make the argument that if the man uses a male method and his wife gets pregnant, he will know that she has been unfaithful.<sup>27</sup> Helzner (1996) also cites program examples in which "male involvement" messages appeal to men's patriarchal role as decision maker in the family. These campaigns "may have achieved higher contraceptive prevalence . . . at the expense of women's equality and right to make decisions affecting their lives." (Helzner, 1996, 149)

Segregating services by sex seems to make less sense when promoting sexual health. As the focus of services changed from family planning to sexual and reproductive health, APROFE and others have realized the importance of serving couples together, in order to coordinate prevention and treatment. Yet in some instances, both men and women clearly prefer separate services. For example, in Peru, INPPARES's focus-group research on men indicated that approximately 90% preferred a separate clinic.<sup>28</sup> Given the need for separate clinics for acceptability, INPPARES providers in Peru in both male and female clinics still routinely encourage men and women to involve their partners. However, they report that only one-third of

the male users take advantage of this option. This situation can stymie efforts to promote sexual health.

The research in Peru has shown the importance of conducting research within each culture. Mexicans and Ecuadorians showed no preference for male-only services. However, even in contexts where male focus groups express the desire, given the obstacles to attracting male users and the experience of most of these clinics, it seems clear that separate services for men would not be financially sustainable outside of densely populated metropolitan areas. In most cases, a clinic's only recourse may be to adjust its in-house approach to patients and to aim its marketing efforts toward both male and female users, so that both feel comfortable.

### **RETHINKING MALE INVOLVEMENT: IPPF'S VISION 2000, ICPD, AND APROFE'S 1997 FOCUS GROUP STUDY**

The movement within the field of family planning to broaden its approach to include a comprehensive and rights-based model of reproductive and sexual health services gathered momentum within the IPPF network of affiliates worldwide throughout the late 1980s. At the IPPF World Assembly in 1992, those efforts culminated in adopting the Vision 2000 strategic plan. Participation in this process, as well as the difficulties experienced in the late 1980s and early 1990s in providing services in men's clinics, caused both IPPF/WHO and APROFE to rethink how best to involve men in reproductive and sexual health.

#### **VISION 2000 (IPPF, 1999)**

Goal 1, Objective #5: To increase men's commitment and joint responsibility in all areas of sexual and reproductive health and sensitize men to gender issues, as an essential element in ensuring women's equality and an enriched couple relationship for both men and women.

Strategy 1.5.1 Investigate male attitudes and bias against family planning and sexual health. Identify the major cultural and political constraints to male participation and support in sexual and reproductive health care practice; identify and implement strategies conducive to the removal of these barriers.

APROFE's directors decided that strategy 1.5.1 from Vision 2000 (see box) was indeed an important first step in increasing the number of male users and meeting their needs. Understanding men's knowledge of and attitudes toward sexual and reproductive health was crucial, as was learning about their views on sexuality and APROFE's services. The directors decided to get suggestions from men on how APROFE might best serve them. For this purpose, Agustín Cuesta of the Evaluation Department designed a focus-group study in six cities in Ecuador, differing by size and by cultural region. Each city had one focus group for low-middle-income men and another for middle-income men. The results, which were combined with the more comprehensive 1987 DHS women-only survey, provided important information about male attitudes and regional differences.

The following is a brief summary of the study's main findings (Cuesta, 1998).

**1.** Men's infidelity within marriage was widely accepted. Men who engaged in unprotected sex with women other than their wives put both themselves as well as their partners at high risk for contracting STIs. This study also confirmed the common perception that men viewed women's infidelity as unforgivable.

2. The period of highest risk for men was before marriage, when unprotected sex and multiple partners were common patterns of behavior.
3. A man's attention to his spouse's sexual satisfaction varied, and conversations on the subject rarely occurred. In addition, men were expected to initiate sex.
4. Men had low tolerance for their wives' refusal of sexual relations, and reacted in ways that either directly or indirectly punished the women. Most men said that their actions did stop short of marital rape.
5. Domestic violence usually resulted from alcohol use, women's "provocative" behavior, and jealousy.
6. Often men who had contracted an STI were reluctant to inform their spouses.
7. All groups showed low acceptance for using a condom and undergoing a vasectomy, and many participants were fearful about modern family planning methods.
8. Many men described the quality of care at APROFE's clinics as being poor. They reported that clinic personnel were unfriendly, that they had long waits before being seen, and that the facilities were unhygienic. Because providers either made no effort to make men feel welcome or, more often, simply ignored them, men viewed APROFE's services as for women only.
9. Men expressed no preference for male-only services, as long as they were treated well and received high-quality service. Men offered many suggestions for improving quality of care and for services that they would find more acceptable. They showed great interest in receiving more information about sexual and reproductive health, and in being made welcome in APROFE's services.

These results pointed to simple changes in providers' behavior—in reception areas and in counseling—to make men feel welcome and to help dispel the perception that APROFE's services are for women only. The findings also helped the I,E,&C team at APROFE understand how to adapt health prevention messages to men's particular sexual- and reproductive-health issues, whether they were users or partners of users. APROFE also used these insights to improve quality of care and attract more middle-income clients, both male and female.

With this orientation on how services needed to adapt and improve in order to serve male clients, APROFE began its concerted efforts to attract more male clients, at the same time as intensive training in quality of care and in gender issues took place institution-wide. The following sections describe different aspects of APROFE's experiences with involving men, with an in-depth look at how gender, quality of care, and rights issues were handled in these experiences.

### **APROFE'S CURRENT MALE INVOLVEMENT INITIATIVE: SUCCESS IN ATTRACTING MEN TO CLINICAL SERVICES**

APROFE used three strategies to attract more men to its clinics:

1. Standard protocols for providers mandated that they encourage female users to involve male partners. The first directive to all personnel was in 1998.
2. Radio campaigns advertising that APROFE provided services for both men and women began in 1996. APROFE had not run ads directed solely to men since the male clinic closed in 1993. Beginning in 2000, however, urology services were advertised on both radio and television.
3. Clinic hours were adjusted to men's schedules. In big cities, all APROFE clinics see patients on Saturdays, and many have extended their weekday hours until 7 PM.

These strategies have proven successful. From 1999 to 2000, the clinics in this study have doubled the number of users who are accompanied by their partners from 545 to 1,121 on average per month.<sup>29</sup>

In Guayaquil, between 2000 and 2001, the average number of users accompanied by partners increased by 74%, whereas the total number of users increased only 11%.<sup>30</sup>

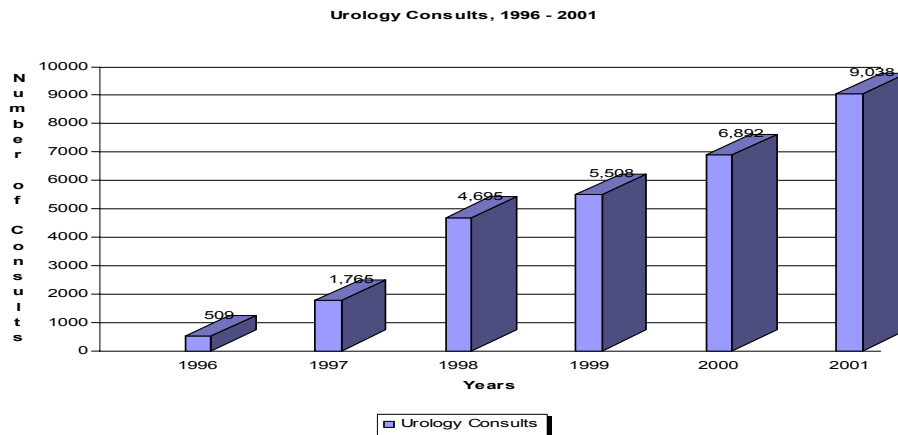
**Average Number of Visits per Month to Five Guayaquil Clinics**

	Jan.–June 2000	Jan.–June 2001	Increase	Percent change
Couples	1,627	2,828	1,201	+74%
Individuals	14,573	16,209	1,636	+11%

Using urology visits in all APROFE clinics as the main indicator for male usage, the number of male users has steadily increased since 1996, with a notable increase of almost 3,000 male users in 1998, when the first directive to APROFE providers went into effect to encourage female users to invite their male partners. This increased usage clearly supports APROFE’s hypothesis that spousal encouragement is the main initial factor responsible for the significant increase in men’s clinic visits. Another above-average increase of more than 2,000 male users occurred in 2001, when APROFE increased its mass-media marketing of urology services.

**Yearly Increase in Urology Visits at APROFE Clinics: 1996–2001**

	Urology Visits	% Change from Previous Year
1996	509	--
1997	1,765	+ 247%
1998	4,695	+166%
1999	5,508	+17%
2000	6,892	+25%
2001	9,038	+31%



The sharp increase in male visits confirmed APROFE's opinion that the key to successfully attracting men was person-to-person interaction—that is, encouraging women to bring their partners to the clinic. After APROFE had established a stable base of male clients and solidified its public image as providing care for both sexes, then mass-media advertising played a greater role in attracting men.

But attracting men to its clinics presented APROFE with many issues: How do gender issues manifest themselves when both male and female partners are involved?

### **PROMOTING MALE INVOLVEMENT AND GENDER EQUITY**

Members of APROFE's gender-training team had widely differing opinions on how to involve men. Some viewed men's involvement favorably only because it would increase women's empowerment, while others viewed men as users in their own right. Before ICPD, the family-planning field involved men in order to change their attitude about women's use of contraception, or to get men to use contraception themselves. A fundamental commitment to human rights, combined with a holistic approach to sexual and reproductive health, entails a commitment to both men's and women's well-being and fulfillment of their rights. Yet, members of the gender training team noted that sometimes these goals seem to be at odds with each other.

*Previous experiences in our context with regard to gender and health took a clear stance in favor of women's empowerment . . . [because women] are especially vulnerable to sexual and reproductive health problems. . . . We had no models that involved men as subjects in their own right, to reconstruct the values of their own masculinity. For the project, this was a challenge and a concern . . . How to involve men from a gender perspective? <sup>31</sup>*

*Las experiencias existentes en nuestro medio, alrededor de género y salud partieron de una opción clara por las mujeres . . . [quienes] se encuentran en desventaja frente a la salud sexual y reproductiva. . . . No existía un referente que partiera de reconocer e involucrar a los varones como sujetos de la construcción y revalorización de su propia masculinidad. Esto se convertía para el proyecto en un reto, un desafío y una preocupación: . . . ¿Cómo involucrar a los varones desde una óptica del género . . . ?*

A gender perspective can empower men as well as women, to help men think and act independently rather than to respond to intense social pressures to conform to traditional male roles. For example, a man may need empowerment to fully share domestic responsibilities, to stop excessive alcohol use, or to allow his wife more freedom of movement. In such instances, he may be ridiculed by his peers and made to feel that his status as a man is put into question. Empowered men must, however, operate within a gender-equity framework so that women are empowered as well.<sup>32</sup> The tension within APROFE's gender-training team on the nature of their commitment to men's health and rights as well as women's mirrored tensions in many other organizations that would seek to involve men in sexual and reproductive health services as well as to preserve their commitment to women's empowerment. This tension is never completely resolved, but rather, organizations and providers constantly experiment to achieve the elusive happy medium. Difficult questions arise in the process, because "incorporating gender" mandates a policy of zero tolerance for abuse of women's rights, and individual men often abuse the rights of individual women. Is it possible to halt men's abuse of power while promoting the rights and well-being of the men being served? How do providers deal appropriately with

couples whose relationships are characterized by the traditional male-female roles of domination and subordination? Where does providers' responsibility in this matter begin and end?

### **Practical vs. Strategic Interests in Gender Theory**

The distinction between meeting women's practical interests versus their strategic interests is useful in considering the application of gender frameworks in sexual and reproductive health programs. In gender theory, practical interests are related to material problems faced by women that have a short-term solution, but may arise from gender inequities. Strategic interests are related to the root causes of these short-term problems, often gender-related inequities and discrimination.

Many APROFE providers who have been confronted with such dilemmas have found ingenious ways to resolve the presenting health problem, thus meeting both women's and men's short-term practical needs. How then can providers take the next step of addressing underlying gender inequities, thus meeting women's strategic gender interests as well?<sup>33</sup>

The following discussion vividly illustrates the ways in which providers have dealt with gender roles, women's rights, and sexuality during clinic visits.

### **GENDER-BASED HEALTH RISKS FOR MEN AND WOMEN**

APROFE's Gender Training Team—led by the I,E,&C Department—studied reproductive and sexual health risks associated with gender roles and constructed protocols of gender-related health risks for training purposes.<sup>34</sup> Many trained APROFE providers demonstrated an understanding of the epidemiological aspects of gender—that is, those aspects that pose risks to health—and could give examples of the questions that they asked to uncover such risks. The following gender-based risks were adapted from APROFE's training document.

#### **Inequitable sexual relationships.**

Staff probe for norms such as multiple partners for men, premature sexual initiation for men, double standards in sexual activity, coercive and violent sexual relations, absence of pleasure or desire (especially for women).

#### **Inequitable power dynamics and violence in couple relationships.**

In many settings, violence is viewed as a normal way for men to interact with women. Furthermore, the power imbalances pose an obstacle to communication and joint decision making within the couple on reproductive and sexual issues.

#### **Inequitable reproductive preferences and relationships.**

For example, son preference leads to more children than desired or to inadequate care for infant daughters. Other examples include lack of male responsibility for family planning, and for reproductive and sexual health care in general.

#### **Inequitable distribution of food within the family.**

Usually women and daughters are disadvantaged and thus more prone to malnutrition. Pregnant and lactating women have special nutritional needs that are often ignored.

### **Inequitable distribution of household work, child care, and leisure time.**

Depending on socioeconomic status and on whether women work outside the home and/or are heads of household, this inequity can lead to excessive burdens on women with severe physical and mental health consequences. Globally, studies of men's and women's leisure time show the tendency for women to have much less.<sup>35</sup>

### **Inequitable access to paid employment and to family income.**

The model of the man as exclusive breadwinner has consequences for both men and women. For women, this can lead to lack of access to family income, overdependence on the male breadwinner, lack of power within the relationship and in society, and difficulties in leaving violent or destructive relationships. For men who are exclusive breadwinners, it may mean health risks due to overwork, and the need to migrate seasonally or have prolonged absences from the home, which in turn puts them at risk for contracting STIs.

## **THE COSTS OF MALE INVOLVEMENT: DEALING WITH PATTERNS OF MALE DOMINATION**

The costs of male involvement are clearly related to traditional gender roles, i.e., to men's exercise of power over women. In relationships characterized by male dominance and violence and female subjugation and fear, treating the couple becomes an exercise in diplomacy and in surreptitious interventions so that women's rights are protected.

Patterns of male domination were the main drawback of male involvement, a problem that is echoed in literature on male involvement in reproductive health. (Helzner, 1996) In a patriarchal culture with both men and women present, men tend to dominate the conversation, while women are silent. Furthermore, men tend to take charge and give orders, as opposed to engaging in shared decision making. In couples in health-care settings, the woman may be less willing to provide vital information to the health provider, becoming a passive participant in caring for her and her partner's health. This disempowerment does not meet women's strategic gender interests.

The most common strategy that APROFE providers have used to mitigate this dynamic is to encourage the woman to speak her mind. Often, providers have had to point out that the man was not letting his partner speak. This strategy usually allows conversations to take place in which both the man and the woman actively participate.

*Sometimes it is very difficult and I try to handle the man's behavior so that he changes a little. This is hard because we have limited time in the clinic visit. I try to have the woman speak up more, by emphasizing that since she is the one with health problems, she should be the one to speak. I have to do this without devaluing the man's presence and his participation. Doctor*

*A veces es muy difícil y trato de manejar al hombre, trato de cambiar un poco. Aquí es un poco difícil por el tiempo de la consulta. Trato de hacer que la mujer tenga un poco más de voz, enfatizando que ella es la que siente y tiene molestias, entonces la indicada para manifestarse en este momento es ella. . . . sin menospreciar que el hombre esté presente, de que participe en la consulta de la mujer. . . . VII,4,7,P, Médica*

This strategy of simple encouragement was not always sufficient. In some situations, after a provider obtained the woman's consent to invite the man into a counseling session, the provider

realized the necessity to talk to the woman alone. One provider asked the woman to schedule another visit, while another simply asked the man to leave the room. These differences in strategies depended on a provider's intuition or concerns about aggressive outbursts from the man, either toward the woman or the provider. More than one provider or counselor reported such fears in similar situations.

*Generally, with a dominant man, he enters first. . . and says, "Do this and that with her." The woman hardly speaks at all. Then I always say to her, "What do you think?" . . . Sometimes she responds, "Whatever he says." Then I say, "But are you in agreement? It is your health, your body." Sometimes I have to ask the woman to return by herself, so that we can talk freely. Due to his jealousy or whatever, we cannot talk with her husband in the room. Intake Counselor*

*Generalmente con este tipo de personas,[varones dominantes] el primero que entra es el varón, y . . . "haga esto y haga lo otro con ella". La mujer casi no habla. Entonces, yo siempre le digo: ¿y usted qué piensa? . . . ? Y, a veces, ella dice: "sí, lo que diga él". Entonces, yo le digo: "pero, ¿está de acuerdo usted? Es su salud, es su cuerpo." A veces, se le pide también a la señora que regrese y cuando está solita conversamos un poco más detenidamente, porque delante de el esposo no se puede, por celoso, por lo que sea . . . X,6, Orientadora*

*Sometimes there are couples in which only the man speaks, he says everything about the women's condition and she is silent. . . Then I have to be careful to respond to him, because he will notice right away if I don't. . . However, I ask the woman directly, "Tell me, what are you feeling? What is bothering you?" At that point, the husband might jump right in, " So, tell her, tell her . . ." and when the woman continues to be silent, the man jumps in again and I have to say, "Hold on a second, . . . we have to see if she will tell me what is going on." . . . If she doesn't, then I have to say to him that I need to see the woman alone . . . and then she usually relaxes and talks to me. . . It has happened to me, when the men are very difficult, that I am afraid to say something to him because he might say something [aggressive] to me as well. Midwife and Clinic Supervisor*

*Es muy difícil, porque hay veces parejas que solo el hombre habla, él dice todo lo que la mujer tiene y ella esta callada. . . , Entonces, yo, claro que hablo con el señor, porque el se deja notar en seguidita, pero trato de preguntarle a la señora directamente, "dígame, señora, qué siente, qué molestias tiene . . .", entonces, a veces, el marido está ahí: "di, pues di", entonces cuando . . . ella sigue muda, entonces el hombre se mete . . . y ahí yo le digo, a ver, un ratito, esperemos, vamos a ver que la señora sí me va a decir qué es lo que le pasa . . . o si no, a veces, le digo que pase sola la señora y le hago preguntas a ella sola . . . y ahí como que se suelta un poquito y dice . . . Porque eso sí me ha pasado, cuando los hombres son muy difíciles, porque también me da miedo decirle algo porque me puede decir algo a mí también . . . XV,10, Obstetriz y Supervisora*

Health providers' influence is only one piece in the entire socio-economic mosaic of gender-related inequities. Nevertheless, providers can be influential in encouraging both men and women to move toward equity—in this case, by encouraging women to speak up and discouraging men from dominating the conversation.

It should be noted that APROFE's training did not initially address the issue of violence against women. For a variety of reasons, APROFE decided to postpone such training for its providers until quality of care and gender concerns were solidly mainstreamed within its services. Therefore, clinical protocols do not include routinely screen women for domestic

violence. APROFE's providers, however, have commented that they often detect cases of domestic violence during clinic visits, either because the woman raises the issue or because of physical evidence during her medical exam. APROFE's providers have been instructed to refer these women to state-run centers set up under Ecuador's domestic-violence law; some clinics also refer women or couples to a staff psychologist.<sup>36</sup>

The imbalance of power and the presence of violence that characterize so many male-female relationships has made protecting women's right to privacy an important challenge when involving men in sexual and reproductive health services.

### **Encouraging Men's Involvement and Protecting Women's Right to Privacy**

As in addressing gender issues in general, APROFE's attention to organizationwide training and quality control in services was an essential prerequisite for involving men within a framework of ensuring respect for women's rights, confidentiality, and autonomy. Key to this framework is ensuring women's right to privacy. Although this may seem elementary, APROFE's experiences have revealed that only concerted long-term attention to these principles in training and supervision can ensure this right.

As mentioned above, APROFE circulated fliers to all personnel mandating that they routinely encourage female users to invite their partners to clinic visits. Every APROFE clinic holds monthly or bi-monthly meetings to discuss important issues and announcements from headquarters. Thus, using such fliers would guaranteed that each clinic would discuss the issues and approaches to encouraging male involvement.

Although the numbers of male users couples did increase, the first flyer that APROFE circulated created some misunderstandings. These misunderstandings, the mechanisms for correcting them, and the ensuing experiences in protecting users' privacy are instructive for similar efforts elsewhere. The first circular simply asked service providers to encourage female users to invite their male partners into the consultation. Headquarters staff did not realize that this could be misinterpreted to mean that men's presence was mandatory. At the national meeting of clinic directors, held annually, comments about the inconveniences of the new male-involvement policy revealed this misunderstanding. Management realized that they needed to clarify the first circular to protect female users' right to privacy. Headquarters then sent the following circular reminding staff that they must always secure the women's permission before inviting men.

#### **APROFE's 1998 Circular Encouraging Male Involvement (second circular)**

APROFE's research shows that the husbands of female users complain that we ignore them when their wives seek our services.

Therefore, once more we urge you to involve men, especially in the initial counseling and education sessions, and even in the medical checkup.

To carry this out, you must proceed with great tact; the involvement that we refer to has to be when the woman requests it. We suggest that you ask the woman privately, out of earshot of her husband, if she wishes him to be present throughout the process of the clinical visit.

*February 19, 1998, signed by Eduardo Landivar Villavicencio, Director of Operations*

Two years later, providers at all levels, from supervisors to nurses' aides, unanimously reported that they received permission from the woman first before inviting the man into the counseling session or examination room. This level of compliance is remarkable, considering the amount of teamwork and attention required. How did APROFE achieve this? Three elements were necessary: 1) the circular, and institutional mechanisms to ensure that all personnel in all clinics are exposed to such circulars; 2) gender-training workshops for all levels of staff in each clinic; and 3) APROFE's regular on-site observation and training program. The gender workshops and individual feedback reinforced the information in the circular, and tailored privacy-protection strategies to each clinic's situation. Providers and trainers were able to discuss ways to address unexpected problems in implementing the suggested procedure.

APROFE's experiences in implementing this new service protocol illustrate clearly the gender-related tensions that arise when balancing male involvement with women's rights and users' right to privacy. Numerous anecdotes illuminate some of the challenges. Two elements in APROFE's protocol have provided clues to the main sources of difficulty in implementing this policy.

### **Achieving the privacy needed to secure authentic consent.**

At what point and through what strategies can providers ask women if they consent to their partners' presence "out of earshot"? Examples include nurses aides whispering to women near the bathrooms, and sending the husband to the cashier's desk. After some trial and error, each clinic in this study devised a more or less straightforward procedure that works in most cases.

### **Protecting users' right to privacy at each stage of the clinic visit.**

The phrase "throughout the process of the clinic visit" points to every provider the client encounters—security guard, receptionist, intake counselor, laboratory technician, nurse's aide, doctor or nurse, and sometime a psychologist. Each provider needs to communicate with the next in order to ensure that the privacy of a user who has *not* consented to the spouse's presence is protected. Furthermore, while the circular did not mention the need to grant permission at each stage of the consultation, it is common that women may want their partners to be present in the visit with the counselor or doctor, but not in the examining room. APROFE's trainers and supervisors now reinforce the need to ask for consent at each stage, which is another important part of working as a team to protect users' right to privacy.

APROFE originally focused on protecting females' right to privacy; its providers now realize that when treating sexual-health problems, men's privacy must also be protected.

*Of course, when a man tests positive for STIs and has not disclosed this to his spouse, he prefers to talk to the health professional alone.* Intake Counselor

*"Claro, cuando hay sospecha de enfermedades venéreas, y aparecen positivos y [los varones] no han tenido confianza de decírselo a su pareja, prefieren hablarlo a solas con el profesional."*

V, 2–3, Orientadora

The interviews with providers illustrated the delicate equilibrium between encouraging a partner's full participation and respecting a user's rights to privacy and confidentiality. Many providers reported that some women refused to have their partners present. Several providers reported that educators, lab technicians, nurses' aides, and intake counselors all asked the crucial question about consent, while encouraging both members of the couple to participate. Note that

the waiting-room educator (*motivadora*) is often the first, and least problematic, contact, since privacy is not compromised during educational interventions. This person is usually the first to ask the woman's (or user's) consent for the partner's participation. The anecdotes below illustrate the importance of teamwork and communication among providers:

*First, the educator gives the user her number [in the queue] and discreetly asks her if she wants her husband to be with her. We respect the user's decision, whether or not she wants him there. However, the educator [who gives information in public in the waiting room] provides information to both. Nursing aide*

*Primero esta la motivadora, le da su respectivo turno y se le pregunta discretamente si quiere que el esposo pase a la consulta y se respeta la decisión de la usuaria, si quiere que pase o no, pero se les da información a los dos desde que entran, por medio de la motivadora. X,2, Auxiliar*

*The laboratory technicians also ask the women if she wants her husband to enter, they always notice if someone is with her. . . . In all of the departments now we do this after the [gender] workshop. Clinic Supervisor*

*En el laboratorio también le preguntan si es que quiere que pase el esposo, siempre están pendientes de si está acompañada o no. Es en todos los departamentos que después del taller se dió un cambio. IX,9, Supervisora*

In some instances, the routine procedure breaks down when a man enters the exam room without his partner's consent.

*Sometimes, men don't accept it when we say to the woman "you come first, and then your husband." They just come right in . . . but when the nurse already knows that the user is coming in a couple . . . we send her to the bathroom before she comes into the examining room, and we ask her then. Clinic Supervisor*

*porque, a veces, no permiten que uno les diga a las señoras "usted pase sola y después pasa el señor" . . . ellos entran ahí dentro . . . En cambio cuando la enfermera ya sabe eso que si viene con la pareja le pregunta a la señora cuando la manda a orinar, entonces . . .XV,10, Supervisora*

Fortunately, providers or spouses can usually rely on traditional views regarding female modesty to persuade even the most domineering men to agree to leave the examining room.

*We don't have many problems with men's involvement, but once, a husband didn't give us a chance to ask her permission and rushed in. His wife sent him out of the examining room. Nursing aide*

*Si, no muchos [problemas con involucramiento del hombre], pero si hay, hubo un caso de una pareja que no dió tiempo de preguntarle a ella sino que él pasó corriendo y la esposa mandó sacarlo del consultorio. X,4, Auxiliar*

When a spouse accompanies a woman to a clinic visit, the examining room is sometimes the only private place where she can speak confidentially to a provider without her husband present.

*Sometimes the husband wants to enter [the examining room] but the wife is not comfortable with that idea . . . then, I tell him the truth, that the patient wants to be seen alone . . . Sometimes, the woman has not had any other opportunity during her clinic visit to tell someone that her husband is abusive . . . and she is able to tell me behind the curtain. Midwife*

*Hay veces que el esposo quiere entrar y la paciente no está cómoda, . . . entonces, una le dice la verdad [al esposo], la paciente prefiere entrar a solas. . . . A veces la señora no ha tenido ningún momento pare decirle a alguien que el esposo es abusivo o que no está de acuerdo con la relación, y lo hacen detrás de la cortina. I, 12, Obstetriz*

These examples illustrate a key problem created by male involvement. Ensuring a woman's privacy can be a logistical challenge to providers.

In the next example, the counselor was able to respect the woman's need for privacy, while persuading her that including her husband in the counseling session would be beneficial. To protect privacy yet encourage a sexual partner's involvement, it is useful to structure a counseling session so that one part of it is private, and the other part includes the spouse or partner.

*At first when a couple arrives, the wife comes in alone. [After the medical history] I suggest that he come in so that they both receive information. Sometimes the woman does not like this idea because she doesn't want information revealed to her spouse about her past life [other sexual partners, abortions]. I explain that this information is private and that I will only touch on general information. We invite the man in, and he asks more questions than she does because generally, he has more doubts. I persuade him to get a check-up for himself. If he is young, we talk about the risks of STIs. Intake Counselor*

*Cuando llega la pareja y pasa la esposa solo . . . [después de la historia clínica] yo le sugiero que lo haga pasar para que reciba la misma información. A veces no les gusta para que no se revelen información de su vida pasada (otras parejas, abortos, etc.), se les explica que esa información es privada, y que aquí solo se maneja información general. Se le integra al varón y es el que mas pregunta porque generalmente tiene mas dudas y se le engancha para un control, si es joven se canaliza a los riesgos de enfermedades sexuales V,2, Orientadora*

Sometimes, despite careful planning, serious problems do arise. In one instance, a conflict erupted when a man found out that his wife was using an IUD. The providers involved fear that the situation could have become violent. Because similar incidents have occurred, APROFE protocols now instruct providers to ask a woman privately whether her spouse knows about her using contraceptives. Women are encouraged to inform their husbands about this and are told clearly that this is their responsibility and decision to make. While providers may urge a woman to speak with her husband about this and even offer to provide her with information that may change his mind about the matter, they also assure the woman that any information she provides will be kept confidential. The following exemplifies how APROFE staff should deal with the situation:

*With this new focus on gender . . . we start out with, "Would you like your husband to participate in this decision?" If the wife says "no," we assume that maybe he doesn't want to, or doesn't know about this [contraceptive use]. We say we can inform him, and she might say, "I don't want you to inform him, I'm afraid." Then we say, "All right, if you like, we will give your husband the*

*information, but if you don't want us to, that is your responsibility. You know best what you are doing and what you need to do for your welfare." Psychologist*

*pero con este nuevo enfoque . . . lo primero que se entra es: "Bueno, ¿querrá participar su esposo en esto toma de decisión?" Y la esposa dice: 'no', a lo mejor no quiere, o no sabe. Pero le podemos informar, y ella dice: 'no quiero que se le informe, tengo miedo'. Entonces, . . . decir, bueno, si usted gusta, le damos [al esposo] la información, pero si usted no quiere, es su responsabilidad y usted está consciente de lo que hace y lo debe hacer, por su bienestar." XIII,1, Psicólogo*

Clearly, a woman who expresses fear of her husband is signaling to a provider that she may be subjected to violence from her husband, and that further questions should be asked.

As in addressing gender issues in general, APROFE's attention to providing training and improved quality of services has been essential for appropriately involving men while guaranteeing women's right to privacy. Without rigorous training and supervision, providers with multiple sites, such as Ministries of Health, would find it difficult to involve men and to ensure users' privacy.

### **APPLYING GENDER FRAMEWORKS AND INVOLVING COUPLES TO PREVENT AND TREAT SEXUALLY TRANSMITTED INFECTIONS**

When APROFE's focus was on family planning, it was possible to serve mainly women because most contraceptive methods are used by women. When its focus expanded to include sexual health, serving only women of reproductive age was no longer appropriate. To effectively prevent and successfully treat STIs, it is key to involve men, and to treat spouses and other sexual partners.<sup>37</sup> Is it then also possible to use the occasion of an STI diagnosis to address other underlying gender-based inequities? In other words, can both strategic and practical gender interests be addressed?

In most cases, APROFE providers reported successfully involving men in preventing and treating STIs but offered few examples that addressed power dynamics within the couple that keep women from preventing and treating infection. Using the gender lens, curing an STI serves both the man's and the woman's practical interests. Following standard guidelines, APROFE's staff focused on involving men sufficiently to cure the infection and to provide education to prevent re-infection. Curing an infection by treating the couple is an important advance over treating women only—an advance in which providers justifiably take considerable pride. However, without addressing the gender dynamics at the root of the infection, the couple's strategic interests are not served.

One obstacle to addressing strategic gender interests shows up clearly in this study: diagnosing couples with STIs created emotionally charged situations for both the couple and the provider. Most providers in such clinics are biomedically-trained professionals with limited training in counseling, and the demands of the situation often exceed their level of preparation. In these cases, their teamwork with the intake counselor, or with the in-house psychologist (in two of the large clinics), was an essential part of APROFE's services.

### **APROFE's Standard Approach to STIs**

How can biomedical professionals be trained to handle the stress and emotional issues that arise after diagnosing an STI? APROFE promotes strategies that discourage mutual blaming and encourage focus on treatment. In this manner, they report that they are able to treat most couple for STIs, thus addressing women's (and men's) immediate practical gender interests.

One of the first issues that APROFE's gender-training confronted was providers' tendency to withhold the diagnosis of an STI from a user, fearing an emotional reaction.<sup>38</sup> This doctor described some of the deficiencies of treating STIs before gender training was offered:

*Before we tended to conceal some of the facts about STIs, but they taught us in the gender course that full factual disclosure is important. For example, we have to say that the [symptoms of] herpes or condiloma [HPV virus] can get better, but there is no cure. Sometimes, this scares people.*

Doctor

*Antes se ocultaba un poco lo de las enfermedades de transmisión sexual, pero nosotros somos frontales, porque eso nos enseñaron en género, que hablemos frontalmente las cosas. Que se diga, por ejemplo, que el herpes mejora, pero no se cura; de que el condiloma mejora, pero no se cura. A veces, la gente se queda asustada . . . XII,5, Médico*

The gender-training course and the follow-up training team have helped providers follow a standard practice for dealing with STIs, which is to disclose all the medical facts, focus on the cure, and move ahead with treatment. "Let's not focus on who is to blame" was the refrain APROFE providers used when speaking to couples who have been diagnosed with STIs. Ideally (as in the next example), the provider recognized when the couple needed help to deal with the emotions provoked by the diagnosis, and offered to refer the couple to a psychologist or intake counselor, who has been trained in psychology or social work.

*I would like to point out . . . conflicts when we try to apply gender perspectives in cases of STIs. The woman asks me, "So, the transmission is solely sexual? So he gave it to me?" I respond, "I can't say that. We are not here to place blame; this is a disease within the couple. Talk with him." There are men who admit that "I [might have gotten infected] in that place," but rarely will they say this with their partner present. Then I give her informational pamphlets . . . This is when integrated teamwork is so important. They have the option of returning to the intake counselor, because this is difficult, it is a shock for the patient and for the couple. . . . I have to tell them that it is an STI, but that there is a solution [this is a case of a curable STI] . . . I encourage them to focus not on the problem, but on the solution. Doctor*

*Hay un punto que quiero tocar, que es conflictivo en aplicar género con las enfermedades de transmisión sexual, porque la mujer pregunta "Sólo sexualmente? O sea, ¿él me pasó?" Respondo "No le puedo decir. No estamos aquí para ver culpables. Es una enfermedad de pareja. Converse con él," y se le da la información en folletos. Hay hombres que dicen, que si, que yo en tal parte . . . (pero enfrente de la pareja, difícil) . . . Ahí viene la integración y trabajo de equipo. Ellos tienen la opción de ir a orientación, porque es difícil, pues es un shock/impacto para la paciente y para la pareja. . . . tengo que decirle que es un ETS, pero que hay solución, . . . digo " No se ofusquen en la situación de que tiene un problema, sino busquemos la solución al problema." VIII, 4, Médica*

Naturally, the standard procedure does not always work. Furthermore, the clinician may not have the time or the opportunity to address the underlying causes of the STI, thus requiring a professional trained in counseling to be available for the important follow-up sessions. Most small clinics do not have personnel who are trained to deal with these sensitive issues.

### **Cases In Which Male Involvement Is Not Possible**

In some couples, the woman does not consent to involving her partner because of the man's dominance and mistrust, and/or her fear of her partner's aggression, making male involvement impossible. The dynamics of the couple's relationship are too unequal and fear-ridden to allow proper medical treatment, which means the infection cannot be eradicated completely. These cases clearly illustrate how gender-related power inequalities within couples pose important obstacles to preventing and treating STIs. When a woman is so fearful of her husband that she does not dare tell him the diagnosis, how can this and future infections be treated and prevented? The following anecdote exemplifies these gender dynamics.

*Many times when women come alone and we diagnose an STI, we explain the situation to them, and they prefer to say nothing to their spouses . . . because their husbands are aggressive and they will think that the wives have had sex with other people. The women prefer to keep silent and treat themselves with herbal remedies, waiting until the men realize that they are infected, and seek treatment. Doctor*

*Muchas veces cuando hay una enfermedad de transmisión sexual y las mujeres vienen solas y uno les explica a veces prefieren no decírselo que los esposos . . . porque los esposos son bravos, y van a pensar que ellas han estado con otras personas, y prefieran callarlo y tratarse con hierbitas, y esperar que el se de cuenta que está infectado el lo trata por su parte, no? VI,7, Médica*

In this case, the woman does not know whether her husband is treating himself and whether she should treat herself simultaneously. With so much fear and so little communication, the couple will just keep re-infecting each other. Yet APROFE providers must respect the woman's decision. If she does not want her husband to know, they can do nothing except point out to her the medical consequences of her decision.

In cases such as these, the only way to involve men may be to offer a community-education program on gender issues, or to provide other educational activities that would be directed specifically toward men.

### **Meeting Practical But Not Strategic Gender Interests**

Several anecdotes illustrate both the benefits and the problems with men's involvement in sexual and reproductive health when strategic gender interests are not addressed in relationships in which machismo prevails. The provider below and several others worked within the limits of the patriarchy by using their authority to convince the male partners of the importance of following the doctor's orders, especially when these involve abstaining from sex. At least three doctors in the study found male partners so difficult to convince of the infection's severity that they had these men look at their partners' infected cervix. In these cases, the doctor's power and legitimacy made the treatment work, because the woman did not have enough power in the relationship to convince the man to comply with treatment. The doctor provided the only way to correct the power imbalances within the couple during the clinical visit. Then, once the man was convinced, he usually became involved and complied with the doctor but also tended to assume control of the woman's treatment, removing all agency from her.

*When we have found cervicitis and lesions and give treatment with cauterization, we have had problems when we tell a woman that she cannot have sexual relations for a month. . . . When we see that the spouse does not understand, we invite him in to explain the condition. . . . If the woman*

*consents, we have him come into the examining room so that he can see the cervicitis and see that when his wife complains of pain during sexual relations, it is not because she doesn't want to have sex with him, or because she no longer loves him, but because she is physically sick. He sees the lesion and the situation improves, because he begins to participate in her treatment, and makes sure that she takes her medicine and comes in for her follow-up visit. . . . [They come to follow up and he says,] "Here, doctor, I've brought her in, check her to see how she is, to see if everything is all right."*  
Doctor

*Cuando hemos tenido esas cervicitis, las llagas, hemos tenido también inconvenientes porque cuando le hacemos el tratamiento, después de la cauterización, les decimos que un mes no pueden tener relación sexual. . . . cuando he visto que hay incompreensión de parte de la pareja, yo he invitado al esposo . . . Hemos conversado con él, le hemos explicado en qué consiste . . . si la señora lo ha permitido, lo hemos hecho pasar al área de la consulta ginecológica, para que él vea la cervicitis y vea que cuando la señora se queja del dolor, en el momento de la relación sexual, no es porque ella no quiera estar con él, no es porque no lo quiera, sino es porque en realidad, físicamente, ella está enferma. Él ha visto la lesión y ha mejorado porque él ha participado de la ayuda con ella, ha estado pendiente de que tome la medicación, que venga a la consulta al mes . . . que "doctora, aquí la traje, revísela a ver cómo está, si está bien ya todo . . . " XVI,10, Médica*

This situation is better than the one in which the levels of fear and mistrust were so high that the man could not be involved at all. In this case, the man was actively involved in promoting his partner's health, and in the process protected his own as well. The infection could then be cured, when previously it could not. However, the woman still had little protagonism or power in protecting her health, or the couple's health. She still needed the doctor's legitimacy to do this for her, and her male partner took control of her treatment.

Gender roles, users' rights, sexual rights, and cultural taboos are all raised when diagnosing and treating an STI. In the following example, in which the man was participating in the clinical visit, but not in the physical examination, the provider was able to understand the causes of an intractable infection only after the woman confided in him privately (i.e., "behind the curtain"). The doctor then had to figure out how to deal with the man's denial of his sexual practices that were causing the infection and with the power dynamics that made the woman unable to refuse painful sexual practices. Undeniably, these are complex and sensitive situations that are very hard to address in the limited time of a clinic visit.

*I had one patient who had terrible [vaginal] infections that did not respond to treatment. One day I asked them about anal sex, and the husband answered, "No, we do not do that." But then the wife told me behind the curtain, "Yes, we do that, and I don't like it. Please tell him that I don't want to do that." Well, I could not exactly say that, but [after the examination] I said to both of them that if by chance they ever had anal relations, this and that could occur, and it would be another reason why the infection could not be cured. I had to convince him indirectly. Midwife*

*Tenía una paciente que tenía unas infecciones terribles, que no cedían, y un día yo le pregunté por las relaciones anales y el esposo me contestó, "No, no las tenemos." Pero después la señora me dice detrás de la cortina, "Si, las tenemos, y a mi no me gusta, Por favor dígame que no las quiero." Bueno, yo no podía decirle esto. Entonces dije que si acaso las tuviera, podría suceder esto y aquello, e incluso sería la razón de no curarse esta infección. Lo que me tocó que convencerlo indirectamente. VI, 12, Obstetrix*

This is another example of dealing with practical gender interests—the immediate problem—without addressing strategic gender interests. Although the woman has not gained any more power to protect her own health or rights in this relationship, she has found someone to intercede on her behalf and will therefore no longer be subjected to a sexual practice that she dislikes, and her infection will be cured.

As mentioned previously, serious conflicts often arise with this diagnosis. One strategy that averts such conflicts emerged from interviews with providers. In this strategy, the providers suggested that one member of the couple—usually the husband—may have contracted the infection before the marriage.

*I try to explain that maybe she is infected because her husband had a relationship before marriage and that the symptoms are only appearing now. Clinic Supervisor*

*Trato de explicarle que talvez ella se contaminó porque su esposo antes de casarse con ella tuvo una relación. XV,7, Supervisora*

Especially for younger couples, this convenient “excuse” may actually be true. The advantage of this strategy is that it minimizes tensions, thus allowing the couple to comply with treatment.

While the convenient maybe-it-happened-before-marriage strategy may simply be sacrificing strategic interests for practical ones, on closer analysis the relative costs and benefits are not so clear. If the infection was indeed contracted prior to marriage, the provider is acting responsibly and helping to minimize conflict by offering this possibility. This strategy does not, however, encourage couples to frankly and openly communicate and may leave one of them to wonder whether the STI was due to infidelity. Such doubts can later poison the relationship. In addition, the strategy does not directly address the gendered double standard within marriage that permits men to have multiple partners but does not tolerate such behavior in women. In many cases, however, in the interest of keeping their relationship positive and offering the benefit of the doubt, both members of the couple may prefer this possible explanation. If the diagnosis and subsequent counseling gives the man (or the woman) enough of a scare and enough information to prevent future infections, at least their future sexual health has been protected.

### **Addressing Both Strategic and Practical Gender Interests**

APROFE’s experiences suggest that the STI visit proved to be a difficult context in which to promote strategic gender interests. When such strong emotions are involved, most providers’ efforts may go to trying to contain them—within the limited time frame of a clinical visit—so that the couple can take responsibility for treatment and future prevention.

A few providers trained in psychology or social work—such as the following intake counselor—reported positive experiences in which they could successfully address both gender and sexual health issues.

*Generally, providers send couples back to me when a homemaker is diagnosed with an STI because this creates a conflict within the couple. I explain that the infection may have been dormant for years [Author’s note: Again, the convenient explanation] but I also explain that men . . . have been socialized and pressured to have sexual relations with no protection. This is how I introduce the*

*gender focus, so that they do not focus on blaming the other, but rather on treating the illness. This helps unite them because they come together for the treatment. Intake Counselor*

*Generalmente, se los remiten aquí a orientación, cuando tiene un ama de casa con una enfermedad de transmisión sexual se crea un roce entre la pareja entonces los remiten y les doy una asesoría de cómo la enfermedad puede venir de años para que ella lo entienda, y se le explica que . . . la forma en que se le ha educado [al hombre] incentivándolo a tener relaciones sexuales sin protección, entonces ahí se introduce el enfoque de género y les explico para que no se produzcan roces y no se busquen culpables y se focaliza al tratamiento de la enfermedad, esto los une mas porque vienen juntos a hacerse el tratamiento.*

V, 3, Orientadora

This counselor was directly alluding to the sexual health risks caused by socialization of men, which pressures them to be sexually active and to take risks. She presented this information in an effort to defuse the anger of a woman who was diagnosed with an STI and to keep her from assigning blame. The counselor implied that after talking with the woman, the next step was a joint visit for treatment. Ideally, this second visit would include a counseling session for the male partner to discuss the health risks associated with male gender roles. The crucial step, then, in addressing strategic gender interests, is to begin to educate users on how traditional gender roles augment their health risks, and to urge them to consider changing their behavior.

Although addressing strategic concerns may be difficult, the learning process within the organization and within the network of IPPF/WHR affiliates might yield promising strategies. This study took place at an early stage in APROFE's process of incorporating gender frameworks. After the gender training, the I,E,&C team implemented a program of constant supervision and training visits that allowed learning to take place throughout the organization.

## **MAINSTREAMING A COMMITMENT TO GENDER EQUITY: CLINICAL AND COMMUNITY-BASED STRATEGIES**

The study of the gender-training program in APROFE illustrates that incorporating a gender-based framework required a three-step process:<sup>39</sup> The first step is to accept that gender roles are socially constructed and not innate. Typically, this is the first educational goal of gender-training programs, and the essential base for any further training on the subject. Interviews with many APROFE providers gave ample evidence of their awareness of this key principle. The second step is to understand the epidemiological aspects of gender roles, i.e., those that pose risks to health. To this end, the I,E,&C Department has constructed protocols of gender-related health risks for training purposes. Several providers were able to discuss some of these risks and provided examples of using them in their counseling.<sup>40</sup> The final and most challenging step is to actively promote gender equity with male and female users and within the communities served. Being aware of inequities and their relationship to health risks is one thing, but working actively to end gender inequities is quite another. In this writer's experience, rarely do health providers in Latin America promote strategic gender interests proactively. For APROFE and most organizations worldwide, this is the next step in the gender-mainstreaming process.

Incorporating this third step in the mission of a health services organization and within the confines of the clinic setting is a long-term process. Health-care providers have many limitations and constraints. They are not trained to provide in-depth counseling on highly emotional issues. They often have lines of users waiting to see them, so that spending more time than usual with one person may serve that user's or couple's interests at the expense of several other users. The

provider is only one actor in a person or couple's life, and usually a minor one. Finally, there are many socio-economic structures and dynamics related to reproductive health, sexual health, and gender inequities over which providers have no control, and which put members of the community at high risk for sexual and reproductive health problems.

Yet, within their limited sphere of influence, health providers have an important opportunity to be a positive influence in an individual's or a couple's life. This study gave some examples of how providers can intervene to promote gender equity while counseling clients. Besides face-to-face interventions, other important educational interventions to promote gender equity within the clinic setting include the availability of brochures on gender-related subjects, videos and talks in the waiting room, and posters on the walls.

Besides these limitations within clinical settings, sociocultural obstacles pose limitations to male involvement in the clinic visit. Strategic gender interests may best be served by complementing service-related strategies with community-education strategies, whether through media campaigns, direct community outreach, or both. These factors have to do not only with stereotypes that providers and women have about men—that they are uninterested or unable to cooperate in sexual and reproductive health services—but also with the men themselves who are, in fact, averse to seeking health care for themselves and with child-care issues during clinic visits when it is the man who cares for the children during his partner's visits. While services can work to overcome these obstacles through individual invitations and through marketing strategies, outreach to men within a community is always an important part of any effort to promote gender equity as well as sexual and reproductive health.

APROFE has taken several steps to mainstream attention to gender issues:

1. In the clinic setting, the I,E,&C team has institutionalized gender-related norms, protocols and standards both in the orientation manual and in the "training supervision" visits, so that gender training is no longer a special project, but rather part of the ongoing business of the organization and an integral part of its continual push to improve quality. In 2001, 14 clinics received training supervision visits, and two gender-training workshops took place at the Quito Pilot Clinic to mainstream gender issues into its operations.
2. In 2001, APROFE staff published 479 articles and news pieces on sexual and reproductive health, some of which incorporated gender issues.
3. APROFE published an informational brochure on sexual and reproductive rights, along with nine other themes related to sexual and reproductive health and gender.
4. APROFE has run a Community Center for Women in Guayaquil that offers training courses to help women (and some men) earn income, and gives educational workshops in the community.

In 2001, besides numerous workshops on sexual and reproductive health topics, the I,E,&C Department gave the following community workshops on gender issues:

Workshop Title	Number of Workshops	Number of Participants
Self-esteem and gender	17	424
Husband-wife relationships and bringing up children	21	421
Gender, health and sexual rights	22	411
Violence against women in the couple	25	753
Women's legal and human rights	12	377

Other ways to promote gender equity within a community might involve participating in advocacy for women's rights, or establishing joint educational programs with the local schools, thus reaching male and female youth. Investment in such community-based health promotion and advocacy is an important indicator that an organization is not just paying lip service, but is truly committed to promoting gender equity.

## CONCLUDING THOUGHTS

Agencies that successfully attract men to their sexual- and reproductive-health services face important challenges in regard to promoting gender equity. APROFE's providers found that when treating couples, patterns of male domination can silence women, and providers have to use great tact so that a woman can express her point of view and provide other information without discouraging the man's participation. Conversely, when a man is ill, he may be reticent, believing in the stereotypical attitude that men should not be weak, or sick.

APROFE's experiences in protecting an individual's right to privacy and confidentiality and encouraging involvement of both sexual partners are instructive as well. Mainly, its efforts had focused on ensuring women's right to privacy; but when its providers began treating men they realized that men's right to privacy was just as crucial, especially in regard to STIs. APROFE's providers found that close teamwork and clear communication among clinic staff were necessary to protect privacy, and I,E,&C staff used training and supervision to continually reinforce the need to adhere to clinical protocols that protected this right. Providers have had to be creative in finding ways to ascertain privately whether a user wanted his or her spouse present at each stage of the clinic visit.

Finally, protecting sexual health and getting people involved as couples proved frequently stressful for providers and couples alike. Strong emotions in response to a diagnosis can complicate treatment. Key constraints are the limited time of a clinic visit and health providers' lack of training for dealing with such emotionally charged situations. APROFE's protocols have made the best of a difficult situation. Although a clinic visit can be an important short-term intervention for curing an infection and delivering information to prevent recurrences, long-term results require sexual- and reproductive-health services to distribute information about preventing STIs throughout the community and within the services themselves. All messages should discuss those aspects of both male and female gender roles that put people at risk, which would also help promote gender equity and address some of the root causes of people's vulnerabilities.

Males' use of sexual- and reproductive-health services creates new situations, challenges, and dilemmas. The main challenge is to involve men while maintaining a commitment to gender equity and users' rights. Precisely because gender-equity practices run counter to accepted sociocultural norms, progress is necessarily uneven within any given institution—some staff are more receptive than others, constant reinforcement is necessary, and ground is lost with staff turnover. Therefore, one-shot training interventions do not produce the desired result. Providers need regular training and supervision mechanisms first to understand and accept gender differences, and then to understand the different problems men and women have as well as the risks that arise from their gender roles. Finally, the culture of an organization needs to incorporate a commitment to promoting gender equity at every opportunity. Without ongoing training and supervision to reinforce this transformation in the culture of an organization, providers will resort to the cultural patterns of gender inequity that they have known since infancy.

APROFE is a good example of an organization that has come to understand that this challenge involves a long-term commitment, and in response has incorporated gender and quality-of-care standards in its training, clinical protocols, and supervision. Combining enforcement with as horizontal an approach as possible, the I,E,&C team decided to call their periodic clinic-oversight visits “training follow up” (*seguimiento capacitante*) and not “supervision.” Thus far, APROFE’s success is due to its making gender frameworks and a high level of quality of care part of its standard practices. These institutionalized processes are an integral part of the way the organization does business, and for that reason, they are much more sustainable than the initial gender-training projects that depended on outside funding.<sup>41</sup> Although gender training was key to introducing new and controversial concepts to the organization, that was only the first step. APROFE has come to realize that incorporating gender frameworks while involving men is a long-term process that requires institutional change, and that this dual challenge is essential for promoting sexual and reproductive health, for achieving high-quality services, and for success in increasing the number of people who use the services.

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## ENDNOTES

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- 1 International Conference on Population and Development in Cairo in 1994. The Programme of Action espouses a comprehensive approach to reproductive and sexual health, a focus on women's empowerment, and respect for reproductive rights.
- 2 "A Critique of the Traditional Planned Parenthood Approach in Developing Areas," a paper published in 1962 by J. Mayone Stycos. "I argued that family planning ideology was guilty of several biases that were impeding the movement's progress," Stycos said. He explained researchers and educators should take advantage of the fact that men's and women's reproductive goals are very similar and include males in clinics and educational programs.  
www.news.cornell.edu/Chronicle/96/12.12.96/planning.html
- 3 The decade between the International Conference on Population and Development in Mexico City in 1984 and the ICPD in Cairo in 1994. The IPPF "Vision 2000" predates the 1994 Programme of Action, and shares the more comprehensive focus on sexual and reproductive health of that document. See section "Male Involvement: Benefits, Costs, and Obstacles."
- 4 Programme of Action of the International Conference on Population and Development, Paragraphs 4.24 – 4.29. Report of the International Conference on Population and Development, 5-13 September 1994, UN Doc. A/CONF.171/13.
- 5 See [www.rho.org/html/menrh\\_bibliography.htm](http://www.rho.org/html/menrh_bibliography.htm) for a comprehensive annotated bibliography of the current literature on the subject.
- 6 This working paper is part of a larger study on APROFE's incorporation of gender frameworks into their sexual and reproductive health services, and on their experiences with gender training. The larger study will appear in a book in progress by the same author, under contract to Praeger, a division of Greenwood Publishing Group, Inc.
- 7 The I,E,&C (information, communications and education) department of APROFE consists of four professionals and one assistant who are in charge of all training and professional development within the organization. The director of the department is Miriam Becerra, and the other members of the IE&C staff are Abigail Carriel, trainer; Aurora Contreras, psychologist and trainer; Maria Quindé, psychologist, trainer, and coordinator of a community-based program for youth and women's development; and Vanessa Arica, administrative assistant. This study interchangeable refers to the "gender training team" and the "I,E,&C team."
- 8 These interviews were transcribed by Graciela Fort-Magnon and Elena Aguila, and coded/organized into themes by Doreen Montag.
- 9 From the World Bank's World Development Indicators Database, April 2002. Gross National Income per capita estimated at US\$1,240 for 2001, using the Atlas method. Tables on Ecuador from <http://devdata.worldbank.org/external/CPPProfile.asp?SelectedCountry=ECU&CCODE=ECU&CNAME=Ecuador&PTYPE=CP>
- 10 Data are based on Ecuador's *Encuesta de Condiciones de Vida*, Feb. 1996. Available from [www.worldbank.org/lms/country/ecuador/docs/metodox.pdf](http://www.worldbank.org/lms/country/ecuador/docs/metodox.pdf). Most observers believe that these statistics have worsened since the severe economic crisis in 2000.
- 11 Data are available from the UNICEF "Child Info" Web site: [www.childinfo.org/eddb/mat\\_mortal/database.htm](http://www.childinfo.org/eddb/mat_mortal/database.htm)
- 12 Preliminary results of the 1999 demographic survey ENDEMAIN conducted by CEPAR. The full document is available at the Website <http://www.cepar.org.ec/documentos/ende99.pdf>.
- 13 For the full history of APROFE, see Estrada, 1996.
- 14 See Shepard, 2002, a study of Profamilia in Colombia, also an IPPF affiliate. Profamilia's process of diversifying services, improving quality, and incorporating gender issues was also driven by changes in the population field due to ICPD and to the withdrawal of external donors, but the conditions for increasing sustainability were much more favorable because of the progressive characteristics of the Colombian health sector reform.
- 15 The Evaluation Unit in APROFE disagrees with this perception, saying that while it is true that APROFE is now attending the newly impoverished middle class, they still attend many people from the lowest income sectors, especially in the family planning services. Communication from Agustín Cuesta, May 2002.
- 16 IPPF continues to support APROFE, but at a much lower level than previous years. APROFE received a \$100,000 grant from The William and Flora Hewlett Foundation, channeled through IPPF, to open an adolescent program. They plan to continue the program on their own resources when the grant ends in July 2003.
- 17 See Shepard, 2002
- 18 INPPARES views this as the major obstacle to attracting clients to their male clinic. Personal communication, Angela Sebastiani, October 2002.
- 19 Interviews with Agustín Cuesta, APROFE, and Alfonso López Juarez, Executive Director of MEXFAM. Kim Best (1998) also refers to this problem.
- 20 Association for Voluntary Surgical Contraception, which has since changed its name to Engender Health.
- 21 In the late 1980s and throughout much of the 1990s, USAID-funded programs had to rely almost exclusively on the CYP criterion, which discourages promotion of temporary non-provider-dependent methods. Providers have to distribute 120 condoms to achieve one CYP, while in Latin America one vasectomy yields 10 CYPs. (Figures from a 1997 USAID

document) Use of CYPs makes the cost-efficiency of sterilizations, IUDs, and Norplant so much higher than condoms that USAID-funded providers had no incentive to help clients prevent STIs. See Fort, Alfredo L. "More evils of CYP." *Studies in Family Planning* 27(4):228-231 (1996).

22 Personal communications with Judith Helzner of IPPF/WHR, and Miriam Becerra and Agustín Cuesta of APROFE

23 Not all of the doctors in the male clinic were urologists; some were general practitioners trained in family planning.

24 Personal communication, Dr. Alfonso López Juárez, May 2002.

25 Personal communication from María Isabel Plata, director of Profamilia, October 2002. Profamilia may be unique because it is the largest of the IPPF/WHR affiliates, with extensive coverage that favors financial sustainability.

26 Personal communication from Angela Sebastiani, director of INPPARES. October 2002.

27 Conversations by the author with providers in several Latin American countries over a span of twenty years.

28 Personal communication with Angela Sebastiani and Manuel Diaz, INPPARES, October 2002.

29 Comparing the 5-month periods from January through May; in 1999 the monthly average was 545 couples, while in 2000, the average was 1,121. Statistics provided by the Evaluation Department.

30 From statistics provided by the evaluation department. These statistics correspond to the five Guayaquil clinics.

31 "Antecedentes: El género en IPPF" from the I,E,&C team document on the project to incorporate gender perspectives to improve quality of attention in the services of APROFE in Guayaquil.

32 See Shepard 1996 and Helzner 1996 for a further discussion of this point.

33 This is a standard theoretical construct in gender theory, first advanced by Maxine Molyneux in "Mobilization without Emancipation? Women's Interests, the State, and Revolution in Nicaragua," *Feminist Studies* 11:2 (Summer, 1985): 227-254.

Caroline Moser built on this contribution and standardized it into the "Moser framework," in *Gender Planning and Development: Theory, Practice, and Training*, London: Routledge, 1993.

34 This section is adapted from the APROFE document, "El Enfoque de Género en Salud Sexual y Reproductiva," which includes lists of questions for providers to ask under each section.

35 Data on time use studies from a sample of 31 countries indicates that women work longer hours than men do in nearly every country. (*Human Development Report*, 1995)

36 Excellent information on addressing gender-based violence in sexual and reproductive health services is available from IPPF/WHR in an analysis of programs runs by their affiliates in Venezuela, the Dominican Republic and Peru, in Guedes et al., 2002 and in the newsletter *Basta!*, available online at [www.ippfwhr.org/whatwedo/basta200203.pdf](http://www.ippfwhr.org/whatwedo/basta200203.pdf)

37 APROFE does not offer HIV/AIDS testing or counseling. In the interviews, there was no evidence that providers routinely refer those testing positive for STIs for HIV testing. These users should be informed that they are at risk for HIV/AIDS.

38 Social science researchers on medical ethics in Latin America have found that doctors' tendency to "spare the patient" by not fully disclosing unpleasant diagnoses is very widespread, especially with diagnoses of fatal or incurable diseases. Meeting at CEDES (Centro de Estudios del Estado y Sociedad, in Buenos Aires) with social scientists and ethicists in mid-1990s.

39 A separate article on APROFE's experiences in gender training is available from the author as a working draft. See footnote 5.

40 This study took place in the initial stages of mainstreaming these concepts, before APROFE's I,E,&C Department had disseminated their protocol, so that awareness of these concepts among the providers was uneven.

41 APROFE received support for gender training from IPPF/WHR, from the Dutch government, and from the John D. and Catherine T. MacArthur Foundation through IPPF/WHR. Under the leadership of Judith F. Helzner, IPPF/WHR carried out many initiatives over a 15-year period to mainstream a commitment to gender equity in the programs of the affiliates.